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DEPARTMENT OF HEALTH AND HUMAN SERVICE

Southwest Region

Food and Drug Administration
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November 1, 2002

WARNING LETTER

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. James H. Hinton
President and CEO
Presbyterian Healthcare Services
P. O. Box 26666
Albuquerque, New Mexico 87125-6666

Ref. # DEN-03-04

Dear Mr. Hinton:

On June 7 through July 2, 2002, Investigator Cynthia Jim of our office conducted an inspection of Presbyterian Hospital's blood bank. Our inspection documented deviations from the Current Good Manufacturing Practice Regulations, Title 21, Code of Federal Regulations (21 CFR) Parts 600 – 680. These deviations cause your blood products to be adulterated within the meaning of Section 501(a)(2)(B) of the Federal Food, Drug, and Cosmetic Act ("Act"). Deviations noted include:

Failure to review all records pertinent to the lot or unit maintained pursuant to the regulations before the release or distribution of a lot or unit of final product, as required by 21 C.F.R. § 606.100(c) (Observation Number 1). For example:

> Numerous errors were noted in the "Quality Control – Leukoreduced Blood Products – Whole Blood/Red Cells" records as well as in the Irradiation Logs reviewed by our investigator. Errors noted included miscalculations in the "% Product Recovered," and the "Residual WBC/μL." Also, there were many instances of blank spaces noted in the records. These errors and omissions were not detected by your quality control unit although a second review of the records had occurred

Failure to adequately train personnel responsible for the collection, processing, compatibility testing, storage, or distribution of blood or blood components to assure competent performance of their assigned functions and to ensure that the final product has the safety, purity, potency, identity, and effectiveness it purports or is represented to possess, as required by 21 C.F.R. § 606.20(b) (Observation Numbers 2, 4, 6, 11) For example:

A unit was collected from a donor listed in the [redacted] as temporarily deferred. The database had not been referenced before initiating the donation. There is no assurance that employees are verifying the deferral status prior to conducting donations.

Also, employees processing whole blood units into Fresh Frozen Plasma and Leukoreduced Red Blood Cells documented the weight of the product in the [redacted] and in the [redacted] instead of the volume, as required.

The blood bag weight used in the calculations was also found to be inaccurate, resulting in incorrect final volume results. The technician documented the empty weight of the bag as [redacted] grams when, in actuality, the bag was found to weigh [redacted] grams.

Failure to document the performance of each significant step in the collection, processing, compatibility testing, storage, and distribution of each unit of blood and blood components so that all steps can be clearly traced, as required by 21 C.F.R. § 606.160(a)(1) (Observation Numbers 3, 5, 10, 12). For example:

A blood bank technician completed data entry in the [redacted] including the time irradiated, before the actual irradiation of the units.

There were numerous data entries that were found to be crossed-out in the log without an explanation.

The original documentation of the manufacturing steps was not entered directly into the [redacted] but was observed to be written on paper which was later transcribed to the log. There is no assurance that such information is transcribed accurately as the original documentation is discarded.

Failure to document that Fresh Frozen Plasma ("FFP") has been processed and placed in a freezer within 8 hours of collection, or within the timeframe specified for use for the blood collecting, processing, and storage system, as required by 21 C.F.R. § 640.34(b) (Observation Number 6). For example:

Whole blood unit [redacted] was collected on June 3, 2002. There is no indication in the [redacted] that shows when the FFP was created. The [redacted] only shows that the products were available on June 6, 2002.

Whole blood unit [redacted] was collected on June 4, 2002. There is no indication when the FFP was created.

Whole blood unit [redacted] was collected on June 6, 2002. There is no indication when the FFP was created. The [redacted] only indicates that the products were available on June 7, 2002.

Failure to maintain adequate processing records to demonstrate all steps in blood processing, as required by 21 C.F.R. § 606.160(b) (Observation Number 7). For example:

Review of your Records of Irradiated Blood Products revealed instances where several units were processed at the same time, although the irradiation container cannot hold more than one unit at a time. Instances include May 10, 2002 [redacted] irradiated at 2300); February 26, 2002 [redacted], irradiated at 1400); January 12, 2002 (units [redacted] irradiated at 2050); and November 13, 2001 (units [redacted] irradiated at 0830).

On several dates, the color change of the [redacted] was not documented or was inadequately documented. These include September 25, 2001, September 27, 2001, October 7, 2001, October 26, 2001, October 31, 2001, November 1, 2001, November 27, 2001, December 17, 2001, February 26, 2002, March 20, 2002, April 7, 2002, April 9, 2002, June 3, 2002, and June 10, 2002.

Failure to assure that the irradiator is performing in the manner for which it was designed, as required by 21 C.F.R. § 606.60(c) (Observation Number 8). For example:

Our inspection revealed that the irradiation timer setting was calculated to give a minimum dose of [redacted] cGy of radiation to an empty container instead of a full container. There was no explanation why the timer setting was calculated for an empty container.

Failure to maintain standard operating procedures to ensure the proper collection, processing, compatibility testing, quarantine, storage, handling, and disposition of blood and blood components, as required by 21 C.F.R. § 606.100(b) (Observation Number 9). Your Standard Operating Procedures ("SOPs") have not been updated to reflect current operation procedures. For example:

The SOP for Leukoreduced Red Cells requires a minimum of [redacted] residual white blood cells per blood component instead of [redacted] Also, your SOP requires QC to be performed on the [redacted] units of red cells, but your blood bank is currently performing QC on [redacted] filtered units.

The SOP, "Irradiating Blood Components," does not indicate the maximum number of units of blood or blood components that can be irradiated at one time. This procedure states, "If irradiating multiple products, place the units in the canister so that the indicators are in the middle."

We acknowledge receipt of your July 18, 2002, correspondence responding to the Form FDA-483 issued on July 2, 2002. Review of your response found it to be inadequate. The proposed corrective actions do not include an effective quality control system to assure that future deviations will be detected and corrected. Although in some cases, you have developed charts outlining the steps to be taken, there were no accompanying, written procedures. More specifically, we have the following comments.

- Attachment 7 includes a table showing the tare weight of empty bags to be used when computing the volume of blood components. This chart lists the weight of Leukotrap SCRC bags as [redacted] grams. During the inspection, our investigator had your technician weigh an empty bag. The weight was found to be [redacted] grams. Please be sure that the weights listed reflect the correct value, as this can have a significant impact on the final product.

- Regarding your procedure, "Irradiating Blood Components Using the [redacted]" your procedure references the maximum number of components per irradiation cycle as "...based on [redacted] The procedure lists the maximum number as [redacted]" During our inspection, Investigator Jim was informed that only [redacted] RBC unit collected internally could fit in the container and that [redacted] units of RBCs obtained from UBS was a very tight squeeze. As discussed during the inspection, the validation of your irradiator must reflect the actual capacity of the equipment and the operations employed by your facility.

- The majority of the attachments are identified as "draft" and do not contain signatures indicating formal acceptance. The timelines given indicate that all of the corrective actions should have been completed by September 30, 2002. Therefore it is expected that all corrections have been finalized, approved, and are in place at this time.

- Many of the observations made by Investigator Jim involve recording errors or missing data, as well as lack of adherence to Standard Operating Procedures that should have been caught by your quality assurance review, but were not. It is imperative that your entire staff, including those who perform the quality review of records, be properly trained. Procedures are only effective if they are followed.

Your response states that [redacted] has been engaged to teach GMP training to your employees. We suggest that you also obtain the services of an independent, outside consultant to evaluate your procedures and to determine the compliance status of your facility.

Our investigator also noted that the position of the QA Coordinator has been vacant for approximately one year and that employees have been conducting the quality control of each others' work. In order to assure objectivity, an independent review of the records should be performed.

The above-identified deviations are not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility to assure that your establishment complies with all requirements of the federal regulations. You should take prompt action to correct these violations. Failure to do so may result in regulatory action without further notice, including seizure and/or injunction.

You should notify this office in writing, within fifteen working days of receipt of this letter, of the specific steps you have taken to correct the noted violations and to prevent their recurrence. If corrective action cannot be completed within fifteen working days, state the reason for the delay and the time within which the corrections will be completed.

Your response should be sent to Regina A. Barrell, Compliance Officer, Food and Drug Administration, Denver District, P. O. Box 25087, Denver, Colorado 80225-0087. If you have any further questions, please feel free to contact Ms. Barrell at (303) 236-3043.

Sincerely,

PURGED

B. Belinda Collins
District Director